PRINTED: 09/27/2012 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER  BROOKEWOOD NURSING CENTER, INC    SUMMARY STATEMENT OF DEFICIENCIES   STREET ADDRESS, CITY, STATE, ZIP CODE 32 RIVER ROAD DECATUR, TH 37322    C(A)   ID PREPER   SUMMARY STATEMENT OF DEFICIENCIES   SUMMARY STATEMENT OF DEFICIENCY   SUMMARY STATEMENT OF DEFICIENCIES   SUMMARY STATEMENT OF DEFICIENCIES   SUMMARY STATEMENT OF DEFICIENCIES   SUMMARY STATEMENT OF DEFICIENCIES   DECATUR, TH 37322    C(A)   ID PREPER   SUMMARY STATEMENT OF DEFICIENCIES   SUMMARY STATEMENT OF DEFICIENCIES   DECATUR, TH 37322    C(A)   ID PREPER   SUMMARY STATEMENT OF DEFICIENCIES   SUMMARY STATEMENT OF DEFICIENCIES   DECATUR, TH 37322    C(A)   ID PREPER   SUMMARY STATEMENT OF DEFICIENCIES   SUMMARY STATEMENT OF DEFICIENCIES   DECATUR, TH 37322    C(A)   ID PREPER   SUMMARY STATEMENT OF DEFICIENCIES   DECATUR, TH 37322    C(A)   ID PREPER   SUMMARY STATEMENT OF DEFICIENCIES   DECATUR, TH 37322    C(A)   ID PREPER   SUMMARY STATEMENT OF DEFICIENCIES   DECATUR, TH 37322    C(A)   ID PREPER   SUMMARY STATEMENT OF DEFICIENCIES   DECATUR, TH 37322    C(A)   ID PREPER   SUMMARY STATEMENT OF DEFICIENCIES   DECATUR, TH 37322    C(A)   ID PREPER   SUMMARY STATEMENT OF DEFICIENCIES   DECATUR, TH 37322    C(A)   ID PREPER   SUMMARY STATEMENT OF DEFICIENCIES   DECATUR, TH 37322    C(A)   ID PREPER   SUMMARY STATEMENT OF DEFICIENCIES   DECATUR, TH 37322    C(A)   ID PREPER   SUMMARY STATEMENT OF DEFICIENCIES   DECATUR, THE ADDRESS CITY, STATE, ZIP CODE STANDARD   DECATUR, THE ADDRESS CITY,	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		CTION UNENTIFICATION NUMBER:		LTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AMALE OF PROVIDER OR SUPPLIER  BROOKEWOOD NURSING CENTER, INC    COM   10	70101011			ı		
BROOKEWOOD NURSING CENTER, INC    A SUMMARY STATEMENT OF DEFICIENCIES   CEACH DEFICIENCY SUMMARY STATEMENT OF DEFICIENCY STATES   CEACH DEFICIENCY MIST SE PRECEDED BY FULL TARK   CEACH DEFICIENCY MIST SEPRECEDED BY FULL TARK   CEACH DEFICIENCY MIST SEPRECEDED BY FULL TARK   CEACH DEFICIENCY   CEAC			445278	B. WING		09/24/2012
REGULATORY ORLSC IDENTIFYNG INFORMATION)   FREE TAG	BROOK	EWOOD NURSING CE	<u> </u>		332 RIVER ROAD DECATUR, TN 37322	TEON (X5)
Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5  This STANDARD is not met as evidenced by: Based on observation the facility falled to maintain the sprinkler system components.  The findings include:  Observation on September 24, 2012 at 2:10 p.m. revealed that lent and paint was on sprinkler heads in the following locations:  1. Residents rooms (lent build up)  2. Janitor's closet in kitchen (painted sprinkler head)  3. Dining room by vending machine (painted sprinkler head)  These findings were verified by the Maintenance Director and acknowledged by the administrator during the exit conference on September 24, 2012.  K 064  K 064  SS=D  Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10  What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?  1. Maintenance department has cleaned the lent and paint off the sprinkler heads in the kitchen, and in the dining room by the vending machine on 10/01/12.  How will you identify other residents having the potential to be affected by the same alleged practice(s) and what corrective action(s) will be accomplished for those residents found to have been affected by the sprinkler heads in the kitchen, and in the dining room by the vending machine on 10/01/12.  How will you identify other residents having the potential to be affected by the same alleged practice(s) and what corrective action(s) will be accomplished for those residents found to have been affected by the site of the sprinkler heads in the heads in the kitchen, and in the dining room by the vending machine on 10/01/12.  How will you identify other residents having the potential to be affected by the same alleged practice(s) and what corrective action will be taken?  1. Maintenance department will closely check sprinkler heads in the area foll	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	
This STANDARD is not met as evidenced by: Based on observation the facility falled to maintain the sprinkler system components.  The findings include:  Observation on September 24, 2012 at 2:10 p.m. revealed that lent and paint was on sprinkler heads in the following locations:  1. Residents rooms (lent build up) 2. Janitor's closet in kitchen (painted sprinkler head) 3. Dining room by vending machine (painted sprinkler head)  These findings were verified by the Maintenance Director and acknowledged by the administrator during the exit conference on September 24, 2012.  K 064 SS=D  Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10  What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice(s) does/do not reoccur?		Required automatic continuously mainta condition and are in periodically. 19.7.	sprinkler systems are inned in reliable operating spected and tested	K 06	What corrective action(s) will be accomplished for those resident to have been affected by the all deficient practice?  1. Maintenance department	ts found eged nt has
health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10  What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice(s) does/do not reoccur?		Based on observation maintain the sprinkle maintain the sprinkle. The findings include Observation on Seprevealed that lent and heads in the following. Residents room:  2. Janitor's closet in head)  3. Dining room by a sprinkler head)  These findings were Director and acknown during the exit confections.  NFPA 101 LIFE SAF	tember 24, 2012 at 2:10 p.m. of paint was on sprinkler glocations: s (lent build up) n kitchen (painted sprinkler vending machine (painted verified by the Maintenance dedged by the administrator rence on September 24,	K 064	the sprinkler heads in: the rooms, janitor's closet in kitchen, and in the dining by the vending machine 10/01/12.  How will you identify other resid having the potential to be affect the same alleged practice(s) and corrective action will be taken?  1. Maintenance department closely check sprinkler have a following any contractors work and/or any paint or debris the have collected on any sprint or debris the same appropriate to the same and so the same and	ne sited the g room on lents ed by what ht will eads in repairs hat may orinkler
BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		health care occupant 9.7.4.1. 19.3.5.6, N	cies in accordance with		What measures will be put into p what systemic changes you will r ensure that the alleged deficient	make to

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Pravious Versions Obsolete

Event ID: 216H21

Facility ID: TN6101

Old menerglesten

If continuation sheet Page 1 of 4

PRINTED: 09/27/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING 01 - MAIN BUILDING 01  B. WING		(X3) DATE S COMPL	ETED
		445278	<u> </u>		09/24/2012	
NAME OF PROVIDER OR SUPPLIER  BROOKEWOOD NURSING CENTER, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 332 RIVER ROAD DECATUR, TN 37322				
(X4) ID PREFIX TAG	/ FACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETI DATE
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5		K 062	systematically check sprinkler heads in the by adding the sprink the monthly room of beginning 10/01/12 How will the corrective action	all le building ler heads to heck list, on(s) be	
	Based on observation maintain the sprink. The findings include Observation on Seprevealed that lent and heads in the following. Residents room 2. Janitor's closet head)	otember 24, 2012 at 2:10 p.m. nd paint was on sprinkler ng locations:	***************************************	monitored to ensure the all deficient practice(s) will not what quality assurance prog put into place.  1. Maintenance depar provide synopsis of room check list in the meetings, beginning	eged reoccur; ram will be tment will monthly se QA	10/17/:
K 064 \$5≠D	These findings were Director and acknown during the exit confection 2012.  NFPA 101 LIFE SAI Portable fire extinguishealth care occupants.	e verified by the Maintenance Medged by the administrator erence on September 24, FETY CODE STANDARD alshers are provided in all notes in accordance with NFPA 10	K 064	K 064  What corrective action(s) was accomplished for those resisto have been affected by the deficient practice?  1. Maintenance deparements of the kitchen's fire expenses.	dents found e alleged tment had	(X8) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		STRUCTION - MAIN BUILDING 01	(X3) DATE S COMPL		
	445278		B. WING			09/2	9/24/2012	
NAME OF PROVIDER OR SUPPLIER BROOKEWOOD NURSING CENTER, INC			5	332 RIVER	RESS, CITY, STATE, ZIP CODE ROAD R, TN 37322	<b>.</b>		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL GC IDENTIFYING INFORMATION)	ID PREFIX TAG	(E	PROVIDER'S PLAN OF CORP ACH CORRECTIVE ACTION S DSS-REFERENCED TO THE AIDERICIENCY)	HOULD BE	(X5) COMPLET DATE	
K 064	This STANDARD is Based on observati	not met as evidenced by: on and record review, the tain kitchen fire extinguisher.	K 064	How w	changed out for one v hydrostatic test perfo documented on 9/26/ ill you identify other re- the potential to be affe	rmed and '12. sidents ected by		
ĺ	2012 at 2:05 p.m. re extinguisher did not performed.  The finding was verif Director and acknow	ord review on September 24, vealed that the kitchen k fire have its hydrostatic test ied by the Maintenance ledged by the Administrator rence on September 24,		correct	ne alleged practice(s) as tive action will be taken Maintenance departm review any fire extingu changed out to make s documentation is curre	? ent will sishers sure all		
K 066 \$S=D	NFPA 101 LIFE SAFI Smoking regulations less than the followin (1) Smoking is prohib compartment where foombustible gases, o and in any other haza area is posted with sig	ited in any room, ward, or	K 066		Should any fire extinguithat are changed out be not to have the proper documentation in place Maintenance departmental and request the documentation or a replacement unit and in Administrator immedia	e found e, then ent will otify the		
(3) di	lirect supervision.  3) Ashtrays of noncor lesign are provided in ermitted.  4) Metal containers was evices into which ash	ed, except when under  mbustible material and safe all areas where smoking is		what systems ure to practice	easures will be put into stemic changes you will hat the alleged deficien (s) does/do not reoccur Maintenance will keep a lifte extinguishers in the last dates of any testine in the last dates	make to it ? a log of the		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SU AND PLAN OF CORRECTION IDENTIFICATION		(X1) PROVIDER/SUPPLIER/CLIA IDENT/FICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING 01 - MAIN BUILDING 01	(X3) DATE : COMPI	SURVEY LETED
	445278		B, WING		09/24/2012	
	NAME OF PROVIDER OR SUPPLIER  BROOKEWOOD NURSING CENTER, INC			TREET ADDRESS, CITY, STATE, ZIP CO 332 RIVER ROAD DECATUR, TN 37322	DDE .	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
K 064	Continued From pa This STANDARD is Based on observat facility failed to main The findings include Observation and rec 2012 at 2:05 p.m. re extinguisher did not performed.  The finding was veri Director and acknow during the exit confe 2012. NFPA 101 LIFE SAF Smoking regulations less than the followin (1) Smoking is prohib compartment where combustible gases, of and in any other haz area is posted with s or with the internation (2) Smoking by patie responsible is prohib direct supervision.	ge 1 s not met as evidenced by: ion and record review, the ntain kitchen fire extinguisher. e: cord review on September 24, evealed that the kitchen k fire have its hydrostatic test  fied by the Maintenance eledged by the Administrator rence on September 24, ETY CODE STANDARD  are adopted and include no ng provisions: bited in any room, ward, or flammable liquids, or oxygen is used or stored ardous location, and such igns that read NO SMOKING hal symbol for no smoking.  Ints classified as not ited, except when under	K 064	performed.  How will the corrective accommonitored to ensure the addeficient practice(s) will not what quality assurance proput into place.  1. Maintenance depareview these logs is beginning in Octob	tion(s) be illeged of reoccur; ogram will be ortment will n QA, oer.  vill be idents found he alleged ontainers put into hekeeping uled to	9/26/12
	design are provided i permitted. (4) Metal containers v devices into which as	ombustible material and safe n all areas where smoking is with self-closing cover htrays can be emptied are areas where smoking is		following each smo beginning 9/26/12.  How will you identify other having the potential to be a the same alleged practice(s)	residents ffected by	

NAME OF PERIOD (X4) ID PREFIX TAG	(EACH DEFICIENCY REGULATORY OR LS	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  Ge 2	A. BUILDIN B. WING _ STI		CTION BULD BE	
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS	ENTER, INC  TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  Ge 2	STI 3 C	REET ADDRESS, CITY, STATE, ZIP CODE  32 RIVER ROAD  DECATUR, TN 37322  PROVIDER'S PLAN OF CORREC  (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	CTION BULD BE	(X5) COMPLET)
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  Ge 2	ID PREFIX TAG	32 RIVER ROAD DECATUR, TN 37322  PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE	(XS) COMPLETI DATE
PREFIX TAG	(EACH DEFICIENCY REGULATORY OR LE	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  Ge 2	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE	(X5) COMPLET DATE
		<del>-</del>	K 066			
K 067 SS=F H win sp	Based on observations smoking regulations. The findings include: Observation on Sept revealed the facility occurrence with self-containers with self-containers with self-containers with self-containers with self-containers with self-containers with confer 2012. NFPA 101 LIFE SAFI deating, ventilating, a with the provisions of accordance with the pecifications. 19.5 9.5.2.2	not met as evidenced by: on, the facility failed to follow  diember 24, 2012 at 3:00 p.m. did not provide metal closing cover devices into be emptied into for smoking  died by the Maintenance ledged by the Administrator rence on September 24,  ETY CODE STANDARD  and air conditioning comply section 9.2 and are installed e manufacturer's 5.2.1, 9.2, NFPA 90A,	K 067	Current self contained stand was fitted with a the DON and ADON, so residents would be un access cigarette butts 9/27/12.  What measures will be put into what systemic changes you will ensure that the alleged deficite practice(s) does/do not reoccu.  1. Another self contained smoker's stand that callocked was ordered. So lock put in place 10/3/  How will the corrective action(monitored to ensure the alleged deficient practice(s) will not rewhat quality assurance programput into place.  1. Maintenance will empt self contained metal so stands twice weekly.	I smoking a lock by o that the lable to on o place or II make to ent ur? If metal en be stand and (12.  (s) be ed occur; m will be by these moker's	10/3/12

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1	ILTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		A. ĐUIL	<b></b>			
İ		445278	B. WING	B. WING		
NAME OF PROVIDER OR SUPPLIER BROOKEWOOD NURSING CENTER, INC				STREET ADDRESS, CITY, STATE, ZIP CODE 332 RIVER ROAD DECATUR, TN 37322		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION	
K 066 K 067 SS≖F	Continued From parpermitted. 19.7.4  This STANDARD is Based on observations moking regulations. The findings include Observation on Seprevealed the facility containers with self-which ashtrays can lareas.  The finding was verification and acknown during the exit confector and acknown during the exit confector. NFPA 101 LIFE SAF Heating, ventilating, with the provisions of in accordance with the provisions of in accordance with the provisions of the service of the ser	not met as evidenced by: on, the facility failed to follow  tember 24, 2012 at 3:00 p.m. did not provide metal closing cover devices into be emptied into for smoking fied by the Maintenance fiedged by the Administrator rence on September 24,  ETY CODE STANDARD and air conditioning comply f section 9.2 and are installed	K 06	56	s found eged	
1	This STANDARD is Based on record rev failed to smoke and f The findings include:	not met as evidenced by: iew and interview the facility ire dampers.		smoke and fire damper maintenance is done an documented.  How will you identify other residuation having the potential to be affect	d	

STATEMEN	AT OF DEFICIENCIES	MILDICAID SERVICES	<del></del>			OMB I	NO. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		445278	B. WING			) O	9/24/2012
	PROVIDER OR SUPPLIER EWOOD NURSING CE	NTER, INC		332 F	FADDRESS, CITY, STATE, ZIP CODE RIVER ROAD	, <u> </u>	5/24/2012
(X4) ID	SHMMADY STAT	TEMENT OF DEFICIENCIES		DEC.	ATUR, TN 37322		<del></del>
PREFIX TAG	! (EACH DEFICIENCY	MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	PREFIX TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLDBF	COMPLETION DATE
K 067	, pag		   K06		ne same alleged practice(s) and prective action will be taken?	what	
	Record review and interview on September 24, 2012 at 11:30 a.m. confirmed that the facility failed to perform the 4-year smoke and fire damper maintenance.				Maintenance called Simplex for information on the 4 year smoke and fire damper		
	Director and acknowledge	ied by the Maintenance edged by the Administrator ence on September 24,			maintenance on 10/9/12, 10/15/12, 10/17/12, and 10/18/12 without results.		
	<del>7 7</del> .			wł en	hat measures will be put into pl nat systemic changes you will m sure that the alleged deficient actice(s) does/do not reoccur?		
					<ol> <li>Todd Grant from Grants Heating and Air will come facility and perform the 4 smoke and fire damper maintenance.</li> </ol>		
				moi defi wha	v will the corrective action(s) be nitored to ensure the alleged cient practice(s) will not reoccu it quality assurance program wi into place.	г;	
				;	<ol> <li>Maintenance department of Administrator will schedule smoke and fire damper maintenance at least every years.</li> </ol>	this	10/18/12